EXHIBIT B
WRITTEN TESTIMONY

Lowell General Hospital

1. **After reviewing the preliminary reports located at www.mass.gov/dhcfp/costtrends, please provide commentary on any finding that differs from your organization's experience. Please explain the potential reasons for any differences.**

Answer: It is very difficult for Lowell General Hospital ("Lowell General" or "LGH") to provide detailed commentary on the findings of the DHCFP contained in the "Price Variation in Massachusetts Health Care Services" (the "Report") without the opportunity to review fully the underlying data supporting the report. However, the findings relative to Lowell General Hospital appear to be directionally correct as it relates to the conclusions that Lowell General Hospital is in the lowest quartile of prices for private payers. As described in Table 16 "Comparison of Hospital Price Relativity Rankings for Medicare and Private Payers", LGH was ranked 4th out of 44 providers at a price relativity of .83 for DRG 560. In addition, LGH ranked 28th lowest (out of 44 providers) in Medicare Prices for non-specific DRGs. Lowell General's quality of care as described in Figure 9 "Quality Relativity and Price Relativity for a Vaginal Delivery" was equal to, or better than, two of its closest competitors, Emerson Hospital and Holy Family Hospital, and LGH's relative price was significantly less than those Hospitals.

The conclusions reached in this report do support the long standing belief of the Lowell General that it is leverage and market position that affect private payer pricing. Lowell General has always been subject to extremely competitive market dynamics, which has resulted in its being in the lowest quartile of payment rates from private payers to hospitals located in the City of Lowell. Nonetheless, Lowell General is financially stable, with growing market share and has invested significant capital into the Hospital over the last 7 years. The DHCFP and the State Legislature should consider Lowell General as a model for the State to help reduce cost trends. Lowell General Hospital's lack of market leverage has required LGH to be highly efficient in delivering high quality, comprehensive care to residents in the Greater Lowell Area. Lowell General has expanded services to include tertiary level cancer services, neurosurgical services, cardiac and vascular services, Level II B (CPAP waiver) Special Care Nursery and a Level III Trauma Center. By expanding the breadth and scope of services it provides, LGH has been able to assure that more patients and residents receive care locally, within the network of LGH-affiliated providers (the "LGH Network"), thereby reducing costs for consumers and improving LGH's ability to be a high quality, viable, and efficient community hospital.

2. **How much have your costs increased from 2005 to 2010? (Percents by year are fine.)**

   a. Please list the top five reasons for these increases, with the most important reason first.

Answer:

Cost increases

Year	Percentage
2005	10%
2006	12%
2007	13%
2008	8%
2009	13%
2010	7%

Reasons for Increases – Average annual increase = 10.5%

1. Expense increases related to volume growth pursuant to LGH's strategic plan to keep patient care local
2. Price increases related to drug, pharmaceutical, and medical supplies
3. Staff recruiting and retention (nursing positions as well as other professions)
4. Benefit costs such as health insurance
5. Physician fees related, for example, to adult and pediatric hospitalist programs and anesthesia

3. What specific actions has your organization taken to contain health care costs? Please also describe what, if any, impact these strategies have had on health care costs, service quality, and patient outcomes. What current factors limit the ability of your organization to execute these strategies effectively?

Answer: Strategies to Contain Health Care Costs

Lowell General Hospital and its affiliated LGH Physician Hospital Organization ("PHO") signed a five year agreement with Blue Cross Blue Shield of Massachusetts known commonly as the Alternative Quality contract. The five- year agreement spans from January 1, 2009 to December 31, 2013. The agreement is a full risk arrangement and is a global payment, budget based model. Lowell General Hospital has performed extraordinarily well in the first two years of this agreement by bending the cost curve and by improving quality scores significantly.

The cost trend reductions have been derived by several factors such as referral, utilization, high cost service management, and improved clinical integration. The referral management process included reducing outmigration through a referral management program. Referrals to other organizations are processed and reviewed by the Medical Directors of the PHO. Referrals are approved if the service needed is beyond the scope of services provided by LGH (tertiary or quaternary care level services), and/or if the patient had an existing relationship with a provider outside the LGH Network and is

continuing treatment for that same condition. The referral management process takes advantage of the low cost structure of the LGH Network by stemming the tide of costly outmigration, while focusing on quality and patient outcomes. DHCFP's conclusions contained in the Report validate the Hospital's perspective and longstanding belief that medical care delivered outside the community by less efficient, higher cost providers, which could have been appropriately provided at LGH, costs the system more.

In addition to referral management, the PHO has worked with its physicians to develop programs to review utilization of high cost areas such as Emergency Room, high cost imaging and other testing. LGH has focused on strategies to reduce costly and inappropriate use of the Emergency Department. According to the DHCFP's July 2010 Report on *Preventable/Avoidable Emergency Department Use in Massachusetts*, Lowell had a lower rate of preventable/avoidable ED visits (125 per 1000 residents) compared to the state average (182 per 1000 residents), despite being designated a medically underserved population ("MUP"). Of the twelve designated MUP areas in the Commonwealth, Lowell was the *only* one that had a lower rate than the state average. The rates for all other designated MUPs ranged from 211 to 353 preventable/avoidable ED visits per 1000 population. LGH and the PHO have successfully implemented strategies to provide primary health care in the lowest cost health care setting appropriate to each patient's level of care needs.

Utilization management has been counterbalanced by the quality component of the Alternative Quality Contract. The PHO and Blue Cross have designed a program to provide incentives for enhanced preventative care, management of chronic conditions and patient experience measures. The physicians and the Hospital work together on improving the quality measures year over year. Below is a table of the quality scores for LGH based upon a five point scale:

Year	Ambulatory	Hospital
2008	2.7	2.4
2009	3.7	3.5
2010 (projected)	4.0	3.9

Factors that limit the Hospital's ability to effectively execute on cost reduction strategies include, but are not limited to, the following:

- The expansion of Provider Physician Networks that have attracted certain specialty groups to leave the LGH PHO in search of higher fee schedules.
- Administrative burdens.
- Demands on Primary Care Physician time to spend on quality and referral management programs.
- Ability to recruit Primary Care Physicians in order to expand capacity and continue to keep patients out of the Emergency Room, as an example of a resulting benefit.

- Ability to keep and recruit a strong, viable Specialty physician network to continue to expand the breadth and scope of services at LGH to keep members from the inconvenience and expense of the higher cost hospitals.
- The long standing culture or belief of many residents in Massachusetts who seek care in any setting without reference to cost.
- The perception that high cost equates to high quality.

4. **What types of systemic changes would be most helpful in reducing costs without sacrificing quality and consumer access? What systemic actions do you think are necessary to mitigate health insurance premium growth in Massachusetts? What other systemic or policy changes do you think would encourage or help health care providers to operate more efficiently?**

Answer: Systematic Changes Needed to Reduce Costs

- Create patient cost sharing differentials between higher and lower cost providers, which would encourage consumers to choose efficient providers for their care.
- Reduce administrative burdens on providers.
- Expand products that reward efficient providers and offer Limited Networks that direct patients to lower cost Providers.
- Limit the ability for large Network Providers to proliferate physician contracting to other community providers.
- Educate consumers to select the right setting to seek medical care.
- Expand risk arrangements like the Alternative Quality Contract that directly incentivizes providers to reduce cost and increase quality.
- Promote greater public transparency of relevant cost and quality indicators for all hospitals in the Commonwealth

5. What do you think accounts for price variation across Massachusetts providers for similar health care services? What factors, if any, should be recognized in differentiated prices?

Answer: LGH concurs with the DHCFP and the Attorney General's conclusion that market position and leverage is a principal driver accounting for a wide variation in payment rates to providers across Massachusetts. Market power, geographic isolation, economic development and political clout are the most important levers used during a negotiation of prices by a provider. Public perception and brand name are extremely important assets to bring to the negotiation table. Differences in acuity could account for differences in rates, and differences in measurable quality outcomes should justify some differentials. Further, LGH acknowledges the need for a differential in rates for teaching and research institutions. Medical education and research are cornerstones of the Massachusetts healthcare system. The training of future physicians is extremely important to all providers in Massachusetts. In addition to teaching programs, LGH acknowledges that higher cost structures are required to maintain transplant programs, clinical research programs and other leading edge research that takes place in many Massachusetts academic medical centers.

6. What policy or industry changes would you suggest to encourage treatment of routine care at less expensive, but clinically appropriate settings? (Routine care is defined here as non-specialty care that could be provided at a community hospital or in a community setting).

Answer: As stated in response to question 4, the expansion of products that encourage patients to seek care at community providers and education of consumers about when they should use community vs. tertiary facilities. One industry change could be to pay all teaching hospitals that perform non-specialty care services at the median payment of all providers for those services. In effect, continue to pay teaching hospitals at the rates that have been negotiated for specialty, tertiary, and quaternary care, but reduce their payments for routine care down to median rates for all providers.

7. **Which quality measures do you mostly rely on to measure and improve your own quality of care?**

Answer: LGH and all other Hospitals have hundreds of quality measures that run across all clinical departments. LGH relies most heavily on those indicators that allow us to benchmark with other hospitals on a state and national level. The Core Measures, which include Acute Myocardial Infarction (AMI), Heart Failure, Community Acquired Pneumonia, Surgical Care Infection Prevention, Perinatal, and Stroke, cover the processes of treating these disease categories, a large segment of our inpatient services. LGH is an active participant in the American College of Surgeon's National Surgical Quality Improvement Project (NSQIP), which allows us to monitor outcomes of care such as mortality rates and morbidity (complications) of surgical patients at discharge and 30 days post-discharge. LGH actively participates with the American College of Cardiology to measure the success of cardiac procedures and maintains a Cancer registry to track process and outcome measures. Nurse Sensitive measures are likewise very important. These measures include inpatient falls and acquisition of pressure ulcers. The reduction and eventual elimination of hospital-acquired infections are key patient safety objectives to protect patients and improve our quality. LGH and the LGH PHO routinely monitor a battery of quality metrics, with the most comprehensive being the quality measure sets included in the BCBSMA Alternative Quality Contract ("AQC"). The measure sets include the Ambulatory and Hospital Sets, as follows:

Ambulatory Incentive Measures (AIM)

Clinical Process Measures
Depression - Acute Phase Rx
Depressions - Continuation Phase Rx
Well Child Visits (< 15 Months)
Well Child Visits (3 - 6 years)
Well Child Visits (12 - 21 years)
Chlamydia Screening (16 - 20 years)
Chlamydia Screening (21 - 24 years)
Appropriate Testing for Pharyngitis
Appropriate Treatment for Acute Bronchitis
Appropriate Treatment for URI
Digoxin Medication Monitoring
Colorectal Cancer Screening
Cervical Cancer Screening
Cardiovascular: LDL - C Test
Diabetes Mngt.: Eye Exam
Diabetes Mngt.: Hba1c Test
Diabetes Mngt.: LDL - C Test
Diabetes Mngt.: Nephropathy
Breast Cancer Screening
Clinical Outcomes Measures
Diabetes HbA1c in Poor Control
Diabetes LDL-C Control (<100mg)
Diabetes BP Control (<130/80)
Hypertension: Controlling High BP (140/90)
Cardiovascular Disease: LDL-C Control (<100mg)
Patient Experiences - Adult (3)
Communication Quality
Knowledge of Patients
Integration of Care
Access to Care

Hospital Incentive Measures (HIM)

Measure
Hospital Clinical Process Measures
AMI Measure
ACE inhibitor or ARB for Left Ventricular Systolic Dysfunction
Aspirin at Arrival
Aspirin at Discharge
Beta Blocker at Discharge
Smoking Cessation Advice/Counseling
Heart Failure Measure
ACE inhibitor or ARB for Left Ventricular Systolic Dysfunction
Evaluation of Left Ventricular Systolic (LVS) Function
Discharge Instructions
Smoking Cessation Advice/Counseling
Pneumonia Measure
Influenza Vaccination Status
Pneumococcal Vaccination Status
Antibiotics within 6 hours
Smoking Cessation Advice/Counseling
Appropriate Initial Antibiotic Selection
Blood Cultures Performed in the ED Prior to Initial Antibiotic Received in Hospital
Surgical Infection Measure
Prophylactic Antibiotic Received Within 1 hr Prior to Surgical Incision
Prophylactic Antibiotic Selection
Prophylactic Antibiotics Discontinued Within 24 Hrs After Surgery End Time
Hospital Clinical Outcome Measures (4)
Acute Myocardial Infarction After Major Surgery
Center Center In-hospital Mortality
Wound Infection Rate
Pneumonia After Major Surgery/Invasive Vascular Procedure
Selected Infections Due to Medical Care
Postoperative Pulmonary Embolism or Deep Vein Thrombosis
Birth Trauma – Injury to Neonate
Obstetric Trauma – Vaginal Without Instrument
Hospital Patient Experience Measures (4)
Communication with Nurses Composite
Communication with Doctors Composite
Responsiveness of Staff Composite
Discharge Information Composite

Lastly, we rely on readmission rates and mortality rates as indicators of care. Even when benchmarks are not always available we do find it helpful to measure our historical trend rates.

8. We found that there is substantial price variation occurring for several types of health care services (although for some more than others), but that the wide variation in prices for hospital care does not appear to represent any corresponding gain in quality based on the existing quality measures that we were able to use in this analysis. Does your organization believe that price is correlated with quality?

Answer: LGH would have no basis other than the Report to reach a conclusion that higher cost does or does not equate to higher quality. LGH is, however, a great example of an organization that has worked tirelessly on improving its reputation and brand, improving the quality of care it provides, and investing in its facilities to expand the scope of services to keep patients local. LGH has been able to do all this while consistently being paid in the lowest quartile of rates among other community hospitals. LGH cannot opine that high cost equals high quality, but we are proof that high quality does not have to mean high cost.

What role do you think quality should play in determining prices, and does the health care community currently collect the right types of quality measures?

Answer: LGH believes that quality should play a critical role in determining prices. Further, we believe that the health plans should follow BCBSMA's example and provide a significant portion of payments based on achieving quality benchmarks. LGH has attempted to contract with other health plans so that they would provide meaningful quality payments, but it has met with limited or no success. Health plans, other than BCBSMA, have not valued quality to the level we would like and believe it should be valued. Moreover, the quality component of the AQC provides the counterbalance to utilization management programs. The AQC quality program is designed to prevent disease, manage chronic conditions in the outpatient setting and manage patients that need inpatient care. In addition, the AQC places heavy weight on outcome measures and patient experience measures. LGH believes that, if the industry could agree on a consistent measure set across all private and governmental payers, there would be both a significant cost reduction and a quality improvement benefit.

9. We found that for many inpatient DRGs, a large portion of patient volume is clustered in the most expensive quartile(s) of providers. Please provide your organization's reaction to these findings.

Answer: LGH is not surprised by these findings. The cachet of the downtown academic medical centers is a huge draw for patients, which we believe explains why a large portion of patient volume is clustered in the most expensive quartile providers. LGH has been seeking to stem the tide of outmigration of patients from our primary service area ("PSA") to other more expensive settings. LGH has grown market share from our PSA by expanding the scope of services, investing in the Hospital facilities to improve the patient experience, improving quality scores and working to improve the brand through clinical relationships with Tufts Medical Center's Floating Hospital for Children (pediatrics), Massachusetts General Hospital (Cancer Care), Lahey Medical Center (Cardiology) and Brigham & Women's Hospital (Trauma).

10. What tools should be made available to consumers to make them more prudent purchasers of health care?

Answer: Public websites with user-friendly search tools to compare hospital cost and quality data that is meaningful, accurate, timely and easily understood. The websites need to also educate consumers on the limitations of comparative data and how to interpret the data in order to make informed decisions on the selection of health care providers. Health plans could better educate their membership about the costs associated with care at various provider settings, and, through the use of cost sharing differentials, drive more patients to lower cost settings.

11. What are the advantages and disadvantages of complete price transparency (e.g., consumers being able to see what prices are paid by carriers to different providers

for different services) from your organization's perspective? What about complete quality transparency?

Advantages of Price / Quality Transparency

- ✓ Educates consumers on the cost variation among providers
- ✓ Highlights the disparity that results from a market driven system
- ✓ Provides LGH with a new marketing strategy and branding opportunity
- ✓ Helps to begin the discussion of "value" among providers
- ✓ May give employers the data needed to help employees choose wisely
- ✓ May provide the data to help design a viable limited network

Disadvantages of Pricing / Quality Transparency

- ✓ Cause migration of physician groups to other provider organizations with higher levels of reimbursement
- ✓ Could mislead the consumer to select the inappropriate setting for care
- ✓ May not account for cost structure variations, e.g., for teaching, research and transplant programs

12. Before your organization decides to acquire new service lines, capacity, or major equipment, does it consider the current capacity of nearby providers? What do you feel the state's role should be in health care resource planning (beyond or including its current Determination of Need process)?

Answer: Lowell General Hospital bases its investment decisions to expand facilities, equipment, programs and services on the current and forecasted unmet needs of our community. In order to evaluate the unmet needs, LGH considers both the capacity and quality offerings of nearby providers. Our mission is to serve the community's health needs through the provision of high quality care that is fiscally responsible, patient-centric and service-oriented. We believe there is significant value to the current Determination of Need process, which assures that all major hospital expenditures are evaluated after having undergone a rigorous community needs assessment and have demonstrated sound financial viability. We do not believe the state's role in health care resource planning should be expanded beyond the current, effective DoN Program. LGH is one year into a two-year project known as the Legacy Project. This Legacy to our community is a $95 million, 200,000 square foot partial replacement facility located on our main campus in Lowell, Massachusetts. The Legacy Project includes a new Emergency & Trauma Center, 3 new ORs, 2 floors of private beds (60 new private beds only 33 incremental), a new lobby, ambulatory care and Labor and Delivery areas are included in the project. LGH is extremely proud of its ability to make an investment of this magnitude for our community. This will be the newest bed tower in the City of Lowell since the 1970's. LGH demonstrated the essentiality of the project to the DoN Program, the bond market, JPMorgan Chase and most importantly to the communities we serve. LGH has operated at or near functional capacity for routine medical surgical patients for the last five years. LGH only has 17% private rooms for adult patients and will move to almost 80% after the

Legacy Building is opened. Irrespective of the current capacity limitations at Lowell General, the project was essential to providing high quality, cost effective, patient-centered care to the communities we serve for decades to come.

13. How ready does your organization feel it is to join, affiliate with, or become an Accountable Care Organization (ACO)? Please explain.

Answer: LGH is well positioned to assume the role as the preeminent accountable care organization in the Merrimack Valley. The physicians of the LGH PHO are clinically integrated with Lowell General and accustomed to managing under a global payment system with their largest payer, BCBSMA. LGH is also well positioned because it offers a continuum of care to meet the needs of our patients.

a. Is your organization interested in joining a Medicare Shared Savings ACO, as recently outlined by the Centers for Medicare and Medicaid Services (CMS)? LGH anticipates filing a letter of intent with CMS by June 30, 2011 to be considered as part of the Pioneer ACO process.

b. If your organization doesn't feel ready to join any type of ACO, what types of supports or resources would it need to be able to join one? Not applicable

14. Does your organization have any direct experience with alternative payment methods (bundled payments, global payments, etc.)? What have been the effects in terms of health care cost, service quality, and patient outcomes?

Answer: Please see responses above referencing LGH's participation in the BCBSMA AQC.

15. Please identify any additional cost drivers that you believe should be examined in subsequent years and explain your reasoning.

Answer: LGH believes that the DHCFP and the Attorney General should review the cost trend results as they relate to the further consolidation of Massachusetts hospitals through mergers and acquisitions. Saints Medical Center ("SMC") is operating under a letter of intent to be acquired by an Investor-Owned company. LGH believes that an acquisition of SMC will substantially increase the cost of healthcare to the businesses and residents of the Greater Lowell Area. The rates of payments by private payers to hospitals affiliated with the entity proposing to acquire SMC are significantly higher than the rates received by LGH and SMC currently. LGH is concerned that its provider network of PCP's and Specialists will be recruited by the promise of higher rates of payment, which will translate into higher costs for the region's businesses and consumers. The acquisition will further continue the costly duplication of services, technology and equipment. We strongly encourage the Attorney General to review the offer Lowell General made to acquire SMC as a viable, not for profit entity that will maintain the charitable mission of healthcare in the Greater Lowell area**.**

16. **Please provide any additional comments or observations you believe will help to inform our hearing and our final recommendations.** LGH has nothing more to comment on.